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ABSTRACT

Sixty selected representatives from 13 western states, as well as other states throughout the U.S., gathered to share their concerns, exchange ideas, and demonstrate their unity for the continued expansion of the ethnic minority role within the health professions. Discussion centered on the degree of effectiveness of educational and governmental institutions to train and support and, subsequently, provide quality health care to those communities most in need. Topics in the area of recruitment, admissions, and retention were examined to determine the continuation of programs designed to increase the participation of ethnic minorities within the entire spectrum of the health care delivery system. Pressing issues such as the legality of minority admission criteria, sensitizing and motivating faculty and administration to meet ethnic minority needs, developing rationale for program planning, and providing alternatives to traditional entry methods were addressed. Discussion from the work groups centered on identifying common issues, determining functions to implement action oriented activity, and delineating feasible activities that could impact mutual goals of health science centers and consumers of health services. Participants identified the need for a community based advocacy group which could respond to health care delivery issues, impact legislation directly affecting ethnic groups and their access to funds for equalization of opportunities, and devise an informational network to participate in planning strategies for quick response to and pressing issues. (NQ)

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First Western Regional Working Conference on Ethnic Minorities and the Health Professions

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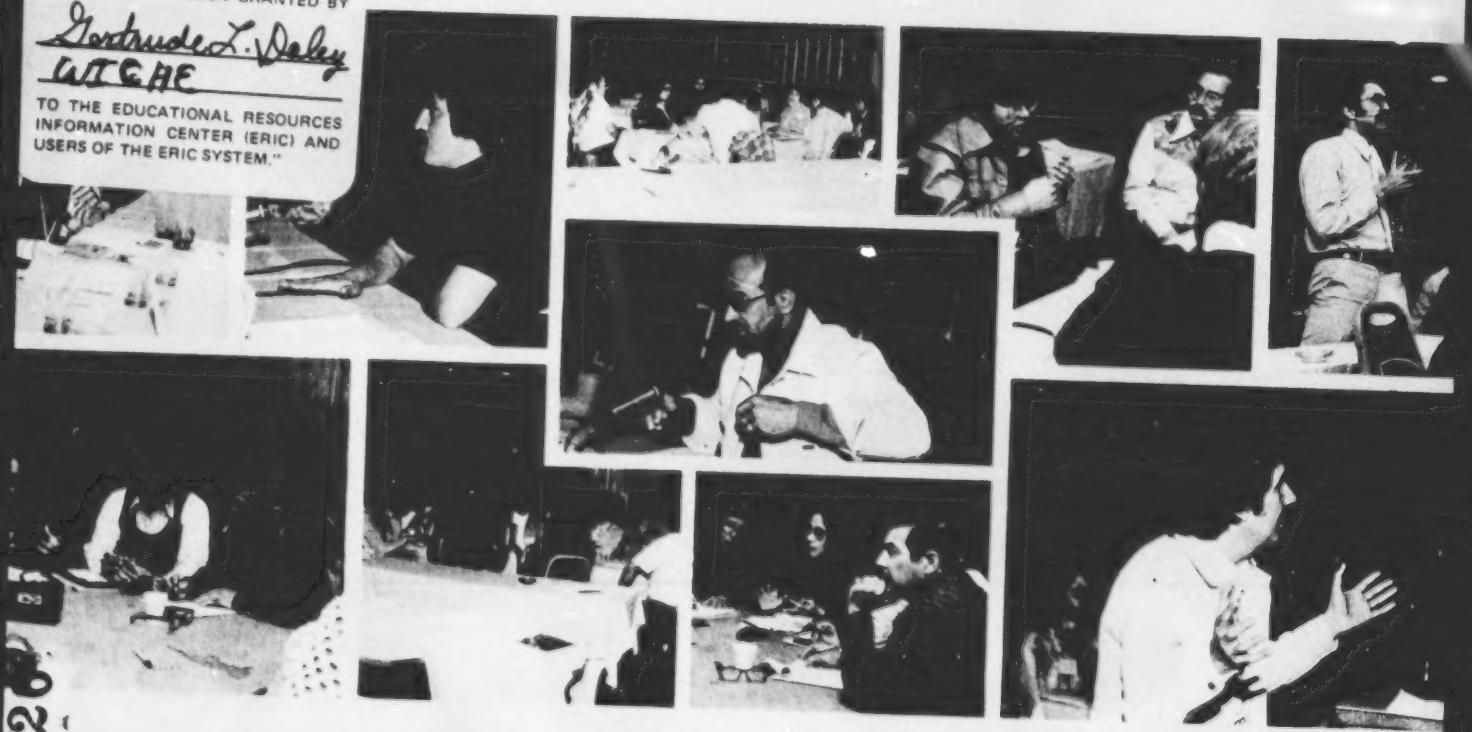

Western Interstate Commission for Higher Education

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WHAT IS WICHE?

WICHE, the Western Interstate Commission for Higher Education, is a nonprofit agency created by the 13 western states. The Commission administers the Western Regional Education Compact, which is an agreement among the states to work cooperatively to improve educational programs and facilities. WICHE was formally established in 1951; program activity began in 1953.

GOVERNING BOARD: Each state is represented on the governing board by three commissioners who are appointed by their respective governors. These 39 men and women, who serve without pay, come from a broad variety of backgrounds including education, state government, medicine, law, business, and labor.

FINANCES: Each member state appropriates $28,000 annually to finance WICHE's general activities. The WICHE Board of Commissioners has approved an increase to $39,000 effective July 1977 for fiscal year 1977-1978. Additionally, the western states can voluntarily each contribute $15,000 to support WICHE's programs in mental health and the human services. The majority of WICHE's individual programs and projects are supported by foundation and public agency funds. For fiscal year 1976-1977 these grant and contract dollars provided approximately 13 dollars for each dollar received from the states.

WICHE's GOALS:

- *Improve the quality of education beyond high school.*
- Expand educational opportunities, including those in continuing education.
- *Coordinate and expand interstate and interinstitutional cooperative programs.*
- Help institutions of higher education improve both academic administration and institutional management.
- *Assist the education community in an appraisal of and in a response to the changing needs of the West.*
- Raise the public level of understanding of the role of higher education.

PROGRAM AND PHILOSOPHY:

- *WICHE serves as a fact-finding agency and a clearing house for information about higher education; it also makes basic studies of educational needs and resources.*
- WICHE acts as a catalyst to help member states work out educational programs of mutual advantage and serves western states and institutions as an administrative and fiscal agent for carrying out interstate arrangements for educational services.
- *WICHE works by building consensus; it has no control over the member states or individual institutions.*
- WICHE serves as a neutral convener on interstate problems in education to build bridges of understanding among all the various constituencies.
- *WICHE cooperates with state, regional, and national agencies, organizations, and institutes for united educational efforts and to avoid duplication whenever possible.*

WICHE MEMBER STATES

Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

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PROCEEDINGS OF THE

First Western Regional Working Conference on "Ethnic Minorities and the Health Professions"

MARCH 23-25, 1976

Salt Lake City, Utah

CONTENTS

Foreword
Phillip Sirotkin iv

Conference Overview
Benjamin L. Cordova v

Part I: Presentations

Keynote Address — Ethnic People of Color and the Health Professions: Our Challenges for This Decade
Marie Branch 1

The Legal Question on Admissions: Are Special Admissions Programs Constitutional?
John Denvir 4

Alternatives to Traditional Entry and Professional Admissions Testing
Alonzo C. Atencio 5

"Superstar" Selection Syndrome: Altering the Selection Process
Paul R. Elliott 7

Two Perspectives: Elementary and Secondary Schools Outreach
Reaching the American Indian Student
Paul Imotichey 9

A Holistic Approach in Recruiting the American Indian
Betty Lambert 10

Postsecondary Recruitment: A Guide to Successful Recruiting
Louis E. Gonzales 11

Two Perspectives: Renovating Models on Retention
Academic Preparation — A Key to Success
Bobbie Ross 15

Developing Skills Programs and Support Services
Donald Yamamoto 17

Motivating Faculty and Administration to Meet Minority Student Needs
Robert Pozos 19

Summer Programs: A Preprofessional Approach
Edwin Marshall 23

Government Funding Outlook
Roberto Aranda 26

Grant Writing: A Question of Survival
Juan Ramos 27

Funding and Foundation Monies Available to Special Admissions Programs
Masato Inaba 29

The Minority Perspective: Redefining the Minority Health Professional
C. Benjamin Moya 33

Part II: Recommendations and Issues from Discussion Groups 35

Part III: Participants 41

FOREWORD

The First Western Regional Working Conference on "Ethnic Minorities and the Health Professions," cosponsored by the University of Utah Health Science Center, the University of Colorado Medical Center, and the Western Interstate Commission for Higher Education (WICHE), was held in Salt Lake City, Utah, March 23-25, 1976. Approximately sixty selected participants were in attendance.

Representatives from thirteen western states, as well as other states throughout the U.S., gathered to share their concerns, exchange ideas, and demonstrate their unity for the continued expansion of the ethnic minority role within the health professions. Discussion centered on the degree of effectiveness of educational and governmental institutions to train and support and, subsequently, provide quality health care to those communities most in need. Familiar topics in the area of recruitment, admissions, and retention were examined to determine the continuation of programs designed to increase the participation of ethnic minorities within the entire spectrum of the health care delivery system. Pressing issues such as the legality of minority admission criteria, sensitizing and motivating faculty and administration to meet ethnic minority needs, developing rationale for program planning, and providing alternatives to traditional entry methods were addressed.

This conference was the first of its kind in the broad areas of the health professions. Never before has a group with such divergent backgrounds come together to work toward achieving a common goal: to involve more minorities in the health professions. Currently, the state of ethnic minorities and their role in the health professions amounts to an unnecessary waste of an untapped resource available and ready to serve if given a fair opportunity to succeed. Established traditional institutions are slowly and painstakingly complying, but long-lasting change is required to accommodate the nontraditional student. WICHE is acutely aware of this deficiency and gives its encouragement to the opening of workable channels to achieve these goals. To this end WICHE has committed itself to meeting the objective of ensuring more representation to ethnic minorities in the health professions.

Phillip Sirotkin
Executive Director
Western Interstate Commission for Higher Education

CONFERENCE OVERVIEW

Developing successful preparatory educational programs in higher education for ethnic minorities interested in pursuing careers in the health professions should be an area of prime concern for college and university staffs in the Western United States. Recently, the staff of the University of Colorado Medical Center, the University of Utah Health Science Center, and the Western Interstate Commission for Higher Education examined closely the state of minority education in the health professions in the western region. Conclusive review suggested that, despite frequent claims of accomplishments, these programs have been relatively unproductive because of several factors. Ethnic minorities are still underrepresented in proportion to their numbers in health professions programs in institutions of higher education. They account for a disproportionately higher share of the attrition rate among students in higher education. And, proportionately, their educational achievements are also significantly fewer than those of the general population students.

In sum, the current state of training for the health professions for ethnic minorities amounts to an unnecessary loss in terms of both individual and community needs in the health areas.

Many problems seem to preclude the potential contribution that training for the health professions could provide to ethnic minorities in terms of health improvement and economic advancement. Institutional recruitment practices regarding admission policies and counseling services are concerned more with numerical representation and required academic standards to comply with government guidelines than with the needs and motivational factors of prospective minority students. Insufficient financial aid, together with the mismanagement of its distribution, discourages the potential educational achievements of these ethnic minority students. This leads to a highly skewed and diluted distribution of professions for these students. Furthermore, the uncertainty of the future of special programs for the disadvantaged student in the health professions places the administration and special services personnel in a precarious position in terms of their own career alternatives, adding still another dimension of frustration. The combination of these and other problems continues to affect, and is related to, the prevailing ineffectiveness of the health professions to recruit and retain ethnic minority students.

Clearly then, problems currently facing ethnic minority students in the health professions are numerous and complex. If the health professions are to become instrumental as social problem-solving mechanisms for ethnic minority health needs, then these institutions, the educational policy makers, and the administrators responsible for the recruitment and retention of ethnic minority students must ensure that:

1. The admissions policies and the recruitment practices of health profession institutions be periodically reexamined in order to accommodate the changing needs of ethnic minorities and their communities.
2. Funding sources in health career recruitment and retention programs be evaluated periodically in terms of their actual impact on the health professions community and reviewed in order to generate the desired educational outcome.

3. The causes for ethnic minority students' attrition be clearly understood, and appropriate institutional policies and practices be developed to reduce this attrition rate.

4. Minority health administrators and related special services personnel be provided with training and continuing education in administration and management skills. e.g., conflict management resource allocation, and planning techniques.

5. Faculty, counselors, and other educational personnel be sensitized to the special health needs and world views of ethnic minorities on the basis of their divergent linguistic and cultural backgrounds.

6. Student financial aid packaging in the health professions be examined periodically in terms of its actual impact and revised to generate the desired educational outcome.

7. An information clearinghouse be established in the western region that would be accessible to those individuals and groups concerned with the advancement of ethnic minorities in the health professions.

8. Intensive, long-term occupational training and career development in the health professions be instituted as an integral part of the education of ethnic minorities.

Thus, while it is clear that these issues were a primary concern of the conference participants, these same concerns are or should be equally critical to others involved in or committed to innovative and successful health career programs. We also believe that through the distribution of this publication other program administrators can become more aware of and sensitive to the needs of ethnic minorities in the health professions.

Benjamin L. Cordova
Staff Associate, Student Exchange Programs
Western Interstate Commission for
Higher Education

ACKNOWLEDGMENTS

I thank all the individuals who planned for and participated in this conference. A special appreciation is extended to my good friend Spike Adams, who worked so diligently on the conference proceedings until his departure for law school, and to Phil Martinez for the exceptional job he did in making the conference a success. Recognition also goes to the WICHE editor, Renee Munoz, for reworking the transcript of the proceedings into a written record that I hope will be distributed to and utilized by many.

My sincere appreciation to Linda Quintana Taylor for her leadership during the conference, to John Alvarez for his active participation in getting people involved, and to Peter Chavez for working so hard to see that the goals and objectives of the conference were realized. Finally, I thank Jim Lopez for his assistance and support throughout the planning and implementation of the conference.

BLC

PART I:

PRESENTATIONS

Keynote Address— Ethnic People of Color and the Health Professions: Our Challenges for This Decade

Marie Branch, R.N., M.A.
Project Director — Models for Introducing Cultural Diversity in Nursing Curricula
Western Interstate Commission for Higher Education

So many of us have been working actively for the last 10 years or more in trying to impact the health profession, not only with numbers of students, but also with a concept that we feel is important and should be woven into the curriculum and considered for practice. In 1971, there was only one nursing program in the West that had a full-time staff person in the School of Nursing whose sole responsibility was to ensure that minority students entered and completed the program. In 1974 there were 18 such positions in schools in the West. Certainly since then there have been many more such positions created all over the country. I think those jobs have not been duplicated in such numbers by schools of medicine, dentistry, veterinary, pharmacy, and so forth; however, many of those programs do have minority coordinators available to them within the minority center.

I want to explain briefly what my project has done with regard to some standard terminology usage. We — those of us who are the racial minority in this country and the racial majority in the world — were very concerned by the use of the term of "minority." The term "minority" tends to only further stereotype groups that we are trying to get to emerge from a particular position. When we looked at the term "ethnic groups," we realized that there are many ethnic groups in this country (meaning white ethnic groups, etc.). So we arrived at the term "ethnic people of color" to designate those groups, who, primarily because of their color, have been victims of racism and oppression in this country. It is significant that many people in the country who tend to want to speak for us have said that this is not an adequate term — it will be interesting to know how we ourselves feel about it.

We began all of this activity about minorities in the health professions on a formalized basis with a background of militancy in the 1960s. Now, just past the mid-way point in the 1970s, we should decide what we have accomplished and what remains to be done. I believe that there are a number of criteria for success.

One criterion, I think, is fairly easy to look at is the numbers game. Although we do not want to play the numbers and color game, nevertheless, if you look at statistics of minorities and women in the health field, partly clarified by a 1974 HEW booklet, two sets of comparative figures are given: one for the late 1960s and one for the early 1970s. There were two directions of action emerging from the civil rights movement: (1) the inclusion of so-called minority or ethnic people of color into the health professions beginning with admittance to school through completion of a program, and becoming licensed for practice; (2) the inclusion of more women into such professions as dentistry, medicine, veterinary medicine, and law — and more men admitted into nursing.

Look at some of the figures. In 1968-1969, the figure for medical schools enrolling minority students was 3.6 percent; that figure grew to 9.5 percent in 1974. In 1968-1969, women were enrolled in medical schools at the rate of about 8.8 percent; in 1974 it was 15.4 percent. There were more than 15 percent women in our programs in 1974 compared to 9 per-

cent minorities. In dentistry the picture is somewhat the same. In nursing those figures have changed from 2 to 3 percent in 1966 and 1967 for minority students enrolled, to 7.7 percent in 1972 and 1973. However, there are still very few men in nursing. The percentage of men enrolled in schools of nursing grew from 1.5 percent in 1966 to 4.8 percent in 1972. Ironically, statistical evidence indicates that the spill-over effect on minority programs has benefited non-minorities more than the people the programs have been set up to serve.

I believe another criterion of success in our efforts to increase minority inclusion, or the inclusion of ethnic people of color, in the health profession is something I call responsiveness. How have minority communities benefited from the increase of their own students in health profession schools? It is my guess that the communities have not fared well for some of the following reasons. For them to fare well, we would have to make sure that the students we recruited and those who entered the profession were students who more suitably met the needs of the community than any other range of students. In other words, these students should be responsive to the community and should be evaluated for admission accordingly. Furthermore, admission criteria should be based on bilingual ability, be evaluated for cultural know-how, sensitivity to social problems, and a dedication to serve the people. Where, in the admission criteria in the schools, is there any reflection of this as the key component of what we are searching for in the new types of students we are bringing into the program?

What we need, and what our communities have said, is that we want mavericks of color; yet we know that it is easier for white radicals to get into medical and nursing school programs that it is for so-called radical Chicanos, Indians or Blacks. By "radical" I mean those people who have shown that, in the face of racism and harassment, they are experienced in affecting institutional change.

Approximately sixty participants attended the conference.

Beyond admissions criteria, we should then look at how the curricula of the schools that we are trying to impact reflect the needs of the community. We would assume that the curricula would spell out, if not support, those students who have entered with some community components, in terms of their characteristics, abilities, and behaviors. The schools should nourish these students in this direction. We would also look for curricula that promote cultural awareness of faculty and staff, and for curricula that have actual teaching components as a required part of the curriculum.

There seem to be two choices. In one sense, we have to act in a leadership role until there are enough people to assume that role for us. Those people who will be setting the direction will be the entering students the young practitioners and the new practitioners.

What disturbs me most is the numbers problem, and that is really representative of the fact that most institutional settings require us to fit the profile of the new students who may be a nontraditional learner and who may have come with valuable aspects.

Until now, historically, those of us who are most like white people (but who have kinky hair, accents, and a different color) are the ones who succeed. That is, the people who are most traditional in terms of community are not getting into school, and many of them who get in are not graduating. I think that is representative of two types of ethnic people of color: those who want a piece of the system for themselves, and those who have dedication to serve community needs, change institutions, and so forth. If we have a choice, we need to try and recruit more people with the skills necessary to graduate who actually can affect institutional and professional change.

There are big tasks ahead of us. One is that we have to work to impact the accountability system; we cannot any longer continue to maintain the position of being on our knees, begging schools to do what we think is necessary to change those statistics I mentioned earlier, and all they represent. We can say that we have impacted the accreditation process when no health profession schools can become accredited unless it has evidenced active programs to recruit and retain ethnic students of color and has active programs to include culture in the curriculum

We must also impact another accountability system — licensure. If culturally relevant information is included on the examination that allows one to practice, then that information will be taught in the schools. We must begin to impact as a body. One person cannot do it, but groups can. Another thing we must do is encourage regular evaluation. If a group at this point

in time cannot list those schools of medicine, nursing, dentistry, pharmacy, and so forth, that we consider a risk for our students to enter, then we have not done our job well. We have had enough time and experiences to know. I think that it is important that we begin such a list. Let us rank schools in terms of their efforts.

We should do this not only to change their admissions criteria, but also other kinds of standards that they hold dear, as well. We should also rank these schools in their efforts to rehabilitate minority students — to help our students become deculturated in the sense that our community can use them effectively.

A third task we have is to instill among our own students a spirit to serve the people. We have special responsibility to do that. We would like to see from them an understanding of their culture and ways — an appreciation of that, not just a theoretical understanding. We would like to know that the people who are entering and graduating from the schools have trust from community groups and can become effective in those groups. Some of us can become effective in the white institutions need even more to be effective on the community level. We need to communicate regularly to those in other parts of the country who do not know what is happening here in the West. We need to communicate regularly between groups of people who are coordinating minority affairs in various places.

My final point is that we must protect those people — faculty, students, and providers — who are already out in the field so they can speak out. We must protect those who institute or press for change, and we must protect those who eventually become, as a result of their activities, generally unpopular with various institutions, or perhaps with the very groups that we are trying to impact. In other words, a Black, Indian, or Chicano faculty member begins to work as an advocate for an institution, so he is not eligible for rehiring or promotion. So we have made some progress, but I think we have some new well-defined problems that the white society has put on us. I think we must begin planning our strategy now, and look at these kinds of major problems. I think we have to set up a protection and support system for those people who are the mavericks and who are running into interference. We have a lot of work to do, and I am pleased to be a part of those who are doing it.

The Legal Question on Admissions: Are Special Admissions Programs Constitutional?

John Denvir, LL.M.
Associate Professor of Law
University of San Francisco

I do not bring encouraging news for the continuation of special admissions for minorities against court challenges. In the case of *Allan Bakke v. the Regents of the University of California* in the Supreme Court of California, the court said "no" to the quota system.

Schools cannot use race, as such, to let people in, even though such admission quotas were designed to correct prior discrimination. This may be good in the long run, for this allows an attack on the traditional admissions system. Clearly, the present system predicts neither the selection of good doctors nor quality service to the community.

There have been several lower court cases that have said the special admissions programs are constitutional, and there is no problem, basically, on the grounds that they are remedying prior discrimination.

The only case ever to go to the United States Supreme Court, the final arbiter, was the Defunis case. The court did not decide that case, so on that issue it has never spoken. The only case that has gone to a very important state supreme court is the Bakke case. I predict the decision is going to be against the idea of a racial quota. Now, if my prediction is correct, which I believe it will be because the judge has been outspoken about it, the court will strike that program down.

From then on, there will be a very strong precedent against racial quotas and special admissions programs, a policy that I think will be accepted by lower courts because the California Supreme Court is influential. Besides that, if the issue ever goes to the U.S. Supreme Court -- substantially more conservative than the California Supreme Court — I think we can expect that court will also strike it down.

The real problem with this decision is that it gives school administrations an out. They can rid themselves of a program they do not want, not because it is unconstitutional, rather, because it becomes an administrative bother after awhile. Thus, these lawsuits give medical schools a chance to say "Because this may be wrong, we will take the safe course and cut the program out entirely."

All that can be required of the law, if my prediction is correct, is that the programs will have to be restructured somewhat so as not to deal in terms of racial quotas. There is nothing constitutionally wrong with this type of program, which is a program that treats certain students who do not do well on verbal tests differently (but who are going to be good health professionals) from white middle-class students who do score well.

Alternatives to Traditional Entry and Professional Admissions Testing

Alonzo C. Atencio, Ph.D.
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Issues relevant to the admission of minority students to medical school is not new. In 1969, the primary movers were minority students and other students concerned with the educational system. The issue then, and now, is the desire to obtain better health care for Blacks, Chicanos, Native Americans, and other ethnic minorities. There is a correlation between the lack of minorities in the medical profession and the next-to-nonexistent health care delivery units, clinics, in the ghetto barrios, and the Indian reservations of this country. The challenge was to make a conscious effort to include more minorities in the health professions by admitting them to professional schools. As a result of student activism and the new awareness, innovative programs were designed to recruit, evaluate, and admit more minorities into the health professions. Unfortunately, many of these programs never got beyond the design stage.

The few that developed, however, had to establish criteria for the evaluation of underrepresented minority students in an attempt to determine their academic potential and reserve. Pressure from minority groups ensured that many of these programs were not abandoned. I do not believe that medical schools can take full credit for this initiative; instead it should go to the minority students and faculty within these institutions.

Now, in 1976, most of these activist students have graduated and moved on to their own practices and other careers. They have left a large void and their absence is now being felt. Without their support, the faculty remaining behind now find themselves isolated within the medical complex.

The new minority student has been led to believe that the institutions are seriously concerned about their training and that their concerns could be detrimental to their academic survival. Now the pace of the medical curricula has been accelerated and the course content has become more rigorous at the same time that retention programs designed to help the minority student survive medical school basic science courses have been withdrawn. This has added pressure on students to spend more time in just passing the courses and medical board exams. The end result has been the creation of a rather intimidated, noninvolved student. Do not forget that the medical educational system is self-replicating, i.e., the clinical professor wants to replicate himself.

Another attitude currently prevailing is that all a premedical student needs is a Spanish or Indian surname to gain admission to medical school. So now, charges of reverse discrimination have been hurled at schools admitting minority students, the obvious implication being that the majority student has been excluded because of the focus on minorities.

Ironically, the activism mentioned earlier led to legislation of Capitation and Physician Augmentation Programs to expand the total medical student enrollment, which rose from about 35,000 in 1969 to about 56,000 in 1976. This represents a net increase of 21,000 students. Because the total minority student enrollment rose only to about 3,000 for Blacks and 540 for Chicanos, most new places (about 17,500) went to majority students. This does not seem like reverse discrimination to me. Presently, there has been

a decline in minority medical student enrollment (1975).

So the projected needs for minority physicians are already being curtailed. Yet to have a Chicano patient to physician ratio of 600:1, about 20,000 Chicano physicians are needed. Instead of reducing admissions, there should be a continuing increase in minority enrollment in medical schools. To continue this, of course, the undergraduate pool of applicants needs to be expanded rather than reduced.

Problems have arisen at our medical schools as a result of admissions procedures for special students. The most glaring issue is the one of student retention. Many of the medical schools are having problems with minority students. You do not flunk 'em out, you simply recycle them through a slower process. There is also the problem that minority students score lower on state and national boards. My school, for me, is looking at this very critically, and, in fact, now has made passage of part I of the boards mandatory for promotion to the third year. Yet, no one has proven that passing the national boards makes one a better physician. To the contrary, it just shows comprehension of the basic sciences. Many students who flunk parts I and II have successfully passed part III and are now practicing medicine.

How do you help a student do his course work in regard to making him a good physician and also help him in taking practice examinations in preparation for the boards? Our school had supportive services such as remedial make-up courses, make-up examinations, and tutorial services to ensure course survival. Yet, these services have been withdrawn now, at a time when the curricula have been intensified.

One reason given is that schools are in deep financial trouble. Capitation grants are presently uncertain. State legislatures are looking at medical school support more critically in terms of health care delivery. The Committee on Economic Development designed a blueprint about three years ago that probably will require the schools to become self-supporting. If that is followed to its logical conclusion, it means that, within five years, medical school tuition will be about $15,000 per year. It is already increasing. Look at Georgetown University — it is $12,000 a year already. What is going to happen to minority programs, especially when financial aid is also being eliminated? These are serious problems.

I believe that lawsuits like those of Bakke and Defunis have gotten too much mileage. They have given medical school administrations an excuse to avoid facing the issue of admitting minority students. Let us look closely at this issue before eliminating minority programs. What alternatives can we develop? At my school, when we examined the minority undergraduate applicant pool, we found very few Native Americans, Chicanos, and Blacks majoring in science. Because the primary criterion is a good science background by which students get into medical school and pass the boards, obviously we need to develop programs to increase the number of ethnic students majoring in science and thereby remove the high-risk label as well.

But that is not sufficient, however, because students from small colleges in New Mexico such as Western New Mexico University or Highlands University do not perform well in the MCATs. We know the MCAT has no predictability as to how successful a physician one will be, although it predicts reasonably well how one will do in the basic sciences and board examinations. There seems to be a continuum from the undergraduate to graduate certification, which means we have to improve educational systems at all levels in relation to minorities. We are attempting to address this problem at the undergraduate level as well. Current undergraduate programs should be improved or new ones should be initiated.

We are also looking closely at the motivation or commitment of minority students to medicine. Sometimes, in our enthusiasm, when we see a minority student with a 3.5 grade-point average and a 600+ MCAT, we immediately assume he will be a good physician. This assumption can lead either to the recruitment of an insensitive person who will not make a good physician or to the placement of a student in the wrong career. I personally know of some students who met the above criteria, and, in reality wanted to go to graduate school. Instead, recruiters talked them into medical school, only to have them leave after a year or two when the basic science curriculum was over.

Although most of what I have said is common sense, admission committees and others concerned with minorities still tend to give minorities a homogeneous quality. In reality, we have our own stratification of personalities within the various ethnic groups. What has really happened is that minorities have been systematically excluded from the educational system for many years. If society is to correct this grave injustice — schools will have to make allowances for the underpreparation of minority students until all have equal access to education.

"Superstar" Selection Syndrome: Altering the Selection Process

Paul R. Elliott, Ph.D.
Director — Program in Medical Sciences
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The term syndrome carries a negative connotation about the selection procedures for the health professions with which I do not totally agree. Clearly, we need students for careers in the health professions who are bright, motivated, sensitive, caring, mature, responsible, community oriented, socially concerned, empathetic, compassionate, honest, mentally and physically healthy, and other-directed. I defy one to assert that such students are not "superstars."

The problem is that (with the possible exception of physical health) all of those descriptors are subjective — including "brightness." Thus, they are difficult to predict in the face of strong socializing factors such as medical education and practice.

The tendency for admissions committees is to rely on measurable performance (not "brightness"), such as academic records and test scores as the primary focus and to use those subjective factors so critical to health professionals as secondary discriminators at best — or at worst, as rationalizations for their decisions based on cognitive performance.

In that light, the term superstar assumes the negative connotation implied in the title of this paper. Worse than that, to the extent that we overutilize grades and test scores for selection, we are selecting persons who are successful within the system — and the system selects for competitive, hard-driving, self-centered, compulsive, and even unethical students — particularly those in the large state universities.

Further, we know that the educational system, as with other parts of our society, has a strong economic bias. No matter which cognitive criterion you use (such as (GPA, MCAT, LSAT, GRE, and SAT), within broad limits the higher the socioeconomic status of the students, the higher one's cognitive performance. Cognitive performance is biased and exclusionary, as well as inappropriate as the singular selection base for the health professions.

Altering the Selection Process

The problems of moving toward a more rational selection process are many:

1. Changing the selection process means altering the entire system including the faculty, who themselves are products and perpetrators of the system. One cannot expect the system to alter itself and in the process exclude itself. Yet, assuming a rational admissions process, students still must face courses, faculty, promotions committees, grades, national licensure exams, and other unchanged products of the system.

One simple reason that cognitive criteria are predictive is that the educational experience in a health professions school is no different than any other level in the educational system. To the extent that an altered selection process creates opportunities for students with lower performance criteria, it can become a revolving door for those students as they face the faculty and courses that have retained their traditional performance bases.

2. To the extent that an altered admissions process opens the door to previously excluded groups, it opens the door to all such groups. The emphasis that began in 1968 on minority student access to careers in medi-

cine has resulted in improving access for women, rural students, low-socioeconomic students, and other nontraditional (i.e., other than white male, 21 years old, upper-middle income, high achiever) students, thus moderating and in a real sense limiting the access for minority students.

3. To alter the educational system at this particular time is a serious challenge. Not only does our society face serious economic problems, but education and educational institutions have been oversold for the last twenty years as the great panacea to society's ills. We are now paying for that.

As the financial support of educational institutions shrinks, administrators become more conservative — grading policies, admissions criteria, curricula — all aspects tend to revert toward 1950. All attempted alterations in the system are rebuffed, as the primary motivation of faculty and programs moves to one of self-preservation.

4. Potentially, the greatest problem is that we could win the battle and lose the war. By this I mean that, at least in the field of medical education, a number of positive alterations have occurred, which could have serious ramifications. As the concern with overspecialization has been made visible, graduate training programs for primary care have accelerated while those for specialty training have been cut back. We are now in the position where selection for certain types of residencies has become extremely competitive (i.e., cognitive, performance based, superstar admissions).

We are approaching the dangerous possibility where traditional students, fully adapted to the system, will be admitted to specialty practice, and nontraditional students (such as low-socioeconomic, minority, women, and rural) will be granted primary care residencies. This will create a dual-level health professional system based on inappropriate criteria applied at the second admissions point.

Summary of the Problem

The superstar selection syndrome is:

- traditional
- well entrenched
- a reflection of the system
- contributory to current problems in the health care system.

It is also:

- Acceptable to a large majority of society
- Difficult to alter in 1976
- Discriminatory and exclusionary
- Not predictive of quality health care professionals.

To alter the selection process alone can:

- Lead to a revolving door for nontraditional students
- Lead to a bi-level profession in which nontraditional members are still on the bottom rung of the ladder.

What Are the Solutions?

The only total solution is to alter the health professions' educational system and the health care delivery system so that quality health care for all members of society can be achieved. Because that is impossible in any but slow, evolutionary alterations, we need to concentrate the revolutionary approaches on those aspects amenable to change.

The immediate and possible solution to the superstar selection syndrome is to begin to look closely at the attributes that are so essential to success in the profession and to quality health care.

The proper modification of the cognitive selection base is not to alter that base, but to add to it. To the degree that we can begin to emphasize noncognitive predictors, learn how to define and measure them, and learn to deal with new kinds of judgments, the door will be opened to the real superstar that we need in the health care professions from any race, religion, sex, and any demographic or socioeconomic background. We do not need special admissions programs. We do need new and broader admissions criteria: relevant to the student, relevant to the real needs of the professions, and relevant to the health care needs of our society.

Elementary and Secondary Schools Outreach: Reaching the American Indian Student

Paul Imotichey
Deputy Project Director
Association of American Indian Physicians

The Association of American Indian Physicians (AAIP) was begun in 1971 by two Oklahoma doctors. One of the purposes behind its formation was to provide a forum of exchange for American Indian physicians in the United States. Another was because they felt there was a need to recruit more Indians into the field of medicine. By this I mean not only medicine, but all the health professions — paraprofessions and allied health fields as well. The third purpose was to provide consultation to governmental and other agencies about American Indian health matters, which involve federal legislative matters pertaining to health. At present, we operate under a contract from the Office of Health Resources Opportunity. The seven subcontractors are the Intertribal Council of Nevada, the Billings Area Indian Health Board, the Northwest Portland Area Indian Health Board, the All-Indian Pueblo Council of New Mexico, the Great Lakes Intertribal Council in Wisconsin, the United Sioux Tribes of South Dakota, and the Phoenix Area Indian Health Board.

There are some interesting statistics that we have developed in the past three years since the inception of our program that I would like to present. The population base of the American Indian is about 1 million. Relating the number of qualified Indian medical personnel to the Indian population, in terms of the ratio needed, we have identified 77 American Indian physicians (or who claim to be American Indian). Of this 77, 44 belong to the AAIP. To properly service the American Indian population with Indian doctors, we really need about 1,475 doctors. There is only one Indian doctor of osteopathy; the amount needed to service the 1 million population base is 66. Dentists: we have only 3 Indians; according to the ratio, our need is 540. Veterinarians: we have 2 Indian veterinarians; our need is 112. Doctors of Optometry: we have identified 2 Indians, our need is 84. Doctors of Pharmaceutical Medicine: we have identified 30; our need is 162. Doctors of Podiatry: we have none; our need is 42.

In addition, this year we have identified between 130 and 135 Indian students who are training in some type of health profession. Obviously, this is a very small percentage of the total number of students in a health profession.

In hopes of reaching the Indians and making them realize that there is a need for the American Indian to become involved in health professions, we have developed the *Health Career Handbook*. Another publication we distribute, primarily to high school and college students, is a small pamphlet containing a questionnaire. The students are asked to complete and return the questionnaire, in which they can request just what information they need, whether it be about any profession or financial matters; we will send it to them.

Concerning the overall recruitment program, we do have a counseling service at the office and we try to coordinate the recruitment effort there. A film has been developed for the purpose of recruiting Indian students — incidentally, this is the first film with an all-Indian cast (no Italians playing Indians in this film!). We are proud of that, and we hope that this and our other efforts will motivate many American Indians to join the health professions.

Elementary and Secondary Schools Outreach: A Holistic Approach in Recruiting the American Indian

Betty Lambert, R.N., B.S.
Health Careers Counselor
N.W. Portland Area Indian Health Board

The problems that exist in the Northwest are no different than those that exist in the Chicano and Black communities in the West. To generalize, school systems in the Northwest often do not believe Indian students can succeed in the health professions because of all the science and math courses. At the present time, my biggest task is working with the counselors in the school system who are trying to work with the parent committee. We believe we are having some measure of success in changing local school administrations and local school systems.

For example, we developed a course in one school that gave the students the opportunity to have a hands-on experience. It was an overview of the health situation, and we gave the students opportunities to do such things as taking blood pressure and doing lab work. We are trying to encourage our Indian students to take science courses. In our recruiting program in the Northwest, we are plugging into those schools that have ongoing programs, like the University of Washington and University of Oregon dental and nursing schools. These are schools where we know our Indian students will get in and will have follow-up.

In our format we also have a summer program in which there are ten students working in health professions. Last year there was one, a second-year medical student working with a doctor in one of our clinics. Thus far, we have developed descriptions for three health administrators, one pharmacist's assistant, and two nurses aides (although two of the students we have are both in nursing programs, one of them a bachelor degree nursing course).

We also try to reach the students who are already in college but have not yet made up their minds where they want to go, so these job opportunities give them first-hand experience. Until the system is changed, until people understand that Indian students are just as capable as anyone else, we can only work within our own locale, with the Indian students and parents who are directly involved.

Participants frequently shared ideas.

Postsecondary Recruitment: A Guide to Successful Recruiting

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Academic Administrator
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In 1968, liberal medical and dental student activists at the University of California, San Francisco (UCSF), researched the admission profiles of students who had entered medical and dental school there. They scrutinized such factors as grade-point average, age, sex, and national origin.

These researchers were amazed at some of the other statistics their work revealed. They found, for instance, that the admissions committee had categorized applicants. Some of these interesting categories were: Mormon veterans, Japanese-Americans from Southern California, Navy dental technicians from the Seventh Fleet, Chinese-Americans born in Hong Kong, and sons of alumni who graduated before 1936.

The research project was completed during a time of increased activism, antiwar feelings, intense student involvement, and a Black Caucus strike. That strike and the research findings resulted in the establishment of an official goal to have each entering class in the schools of dentistry, medicine, nursing, and pharmacy consist of at least 25 percent minority and/or disadvantaged students. This was not intended to be a fixed quota, but a realistic goal to reach out to qualified minority students and to encourage them to consider careers in the health sciences.

An office similar to those of the Educational Opportunity Program (EOP) was established in the Dean's Office. Medical and dental students sent letters to every minority student they could locate, mostly in California.

The first class to include minority and/or disadvantaged students entered UCSF in the fall of 1969. A major change had come to the campus and its effect was felt at all levels — administration, faculty and staff, and student body. Classrooms abounded with racist jokes and faculty antagonism. A most surprising coincidence helped to alleviate the situation and may even have been responsible for saving the entire program. That was the fact that, of the minority students admitted in the first classes, 80 percent were veterans of the military services and at least 75 percent of the faculty were retired military dental officers!

"Super Chicanos" and "Super Blacks" were admitted in those first classes. By "super" is meant that many had master's degrees in engineering. Some were dental laboratory technicians for dentists who do full-mouth rehabilitations (the ultimate in precision and skill). Still others were unemployed school teachers with large families and a need to achieve. Three of these dental students collaborated in writing a grant proposal for the funding of a program in recruitment, admission, and retention. The proposal was submitted to the Department of Health, Education, and Welfare (HEW), which subsequently approved and funded the program for three years (1972-1975).

The new program was multiethnic and multicultural. It included Blacks, Chicanos, American Indians, Filipinos, and women. As had been expected, opposing coalitions arose: Blacks and Chicanos versus Indians and Filipinos. Because of these political hassles funds

for the first year went unspent. There were also personnel problems stemming from the low appeal of "soft" grant money competing with the "hard" money of lucrative private practice.

In spite of our problems, real progress has been made to eliminate many of the inequities that bar minority students from the health professions. Our program has now graduated three classes of dental students, and in June, the Class of 1976 will be graduating more. Of our graduates, over 90 percent have returned to their communities — the rest have enrolled in postgraduate school or enlisted in the military services. Our attrition rate has been practically zero, with less than 1 percent of the students having left the program for academic reasons. One student left for personal reasons, and another transferred to medical school.

Our program addresses some of the serious questions concerning health care that are now being raised by both the state and federal governments. Examples of these are the problems of specialty maldistribution (not enough general practitioners) and geographical maldistribution (lack of health practitioners in rural areas). In our minority communities there is currently a ratio of one Black dentist for every 12,500 Black citizens and there are approximately two practicing American Indian dentists in the United States.

One way to correct the health manpower maldistribution problem is to recruit, admit, retain, and return highly trained minority doctors and dentists to their communities. In our program we actively recruit minority students, help them through the grueling admissions procedure, and, through vigorous tutorial assistance and reinforcement, graduate highly skilled professionals.

The University of California, of which UCSF is one of nine campuses, has recently completed an exhaustive five-year study on Student Affirmative Action by the order of the president of the university. The results of the various task forces were published late in 1975. Consequently, the state of California earlier this year provided $1 million, which was matched by the UC Board of Regents to establish a minority recruitment program in order to fulfill the university's commitment to Student Affirmative Action.

The money was divided so as to provide two recruiters each for eight of the nine campuses, approximately $37,000 per campus. We at UCSF, which is the primary health sciences campus, were not funded.

The latest reports forwarded to me by the Chancellor at UCSF state that "the recruiters could not find *any* qualified minority students who *wanted* to attend the University of California." They prefer to attend local junior colleges free or state colleges for a moderate fee, as opposed to the university for a high fee.

The conclusion reached was that the minority student pool was decreasing. I disagree! The problem lies not in a decreasing pool of minority students, but rather in the process of locating, motivating, and providing follow-up services for these students.

This addresses the question of who should do the recruiting. I personally know many professional recruiters who work in such programs as Upward Bound, the Educational Opportunity Program, university-based programs, and the Legion of the United Latin-American Citizens (LULAC). The university's program for the other eight campuses entails hiring professional recruiters at a minimum cost of $15,500 per year. In contrast, our program, which was not included in the student affirmative action program funding, uses dedicated *volunteer* recruiters who are themselves dental students. These recruiters go back to their high schools, junior colleges, and universities to talk to people interested in a career in the health professions.

Funding from HEW has enabled us to send our student recruiters to specific areas. We pay the round trip airfare and per diem expenses. Considerable savings are realized by having a couple of secretaries in our office make all necessary arrangements. The students work on Thursday and Friday, spend Saturday and Sunday with parents, and recruit on Monday.

One aspect of recruitment I would like to discuss is recruiter credibility. Professional recruiters, no matter how personable they may be, still carry the stigma of being a "counselor," someone not to be trusted. Recruiters who are dental students and a peer have great advantages. They are usually a product of the same neighborhood, the same barrio, the same ghetto, or the same school system. They represent those who have "made it" into professional school by clearing the obstacles and by hurdling the barriers placed in the path of the socioeconomically disadvantaged student.

Look at some specific examples. Upper middle-class students can contact their private dentist, who can offer letters of recommendation from school alumni. Many disadvantaged minority families and students have never been able to afford a regular private dentist or physician. Upper middle-class students have little

trouble applying to 23 professional schools at $20 or $50 per school, a small amount for them or their family. The disadvantaged student is forced to do the unadvisable and apply to only one or two schools.

A dental student recruiter, who has already experienced these obstacles can inform the applicant about requesting a waiver of fees, which involves getting a letter from a local EOP officer. This letter can then be xeroxed 23 times and a copy submitted to each of the 23 schools!

High scores on admission tests do make a difference, especially very high scores. There are commercial businesses that will train applicants to take entrance exams such as the Dental Aptitude Test (DAT) and the Medical College Aptitude Test (MCAT). The upper middle class student pays from $300 to $500 to be trained in taking these tests. The dental student recruiter can tell the applicant about a local $150 DAT-preparatory course that is equally effective. There is another California company that trains students, at a cost of $175 for three weekends, to take the UCSF Manual Dexterity Test. As part of our recruitment effort, we offer to help train the applicant free of charge.

If your father is a dentist he can criticize your work or refer you to a dental alumnus from a particular school in order to find out what that school is looking for in an applicant profile. If you are poor, a participant in the Educational Opportunity Program, or "just barely making it," who can you ask about filling out profile forms? This is another inequity that our program has been able to erase.

Our school seeks "empathetic students who like to work with their hands." The first question on the profile form is not, Do you have empathy? Nor is the second question, Do you like to work with your hands? What *is* asked is, What are your hobbies or favorite pastimes? The "wrong" answer would be, "waterskiing, reading, and listening to the stereo." The "correct" would be, "doing macrame, working with people (Boy Scouts, Big Brothers, etc.), building stereo components, and playing the guitar." The dental student recruiter can show the applicants how to sell themselves by answering the questions "correctly." I cannot overemphasize the importance, in my opinion, of the dental student recruiter as a role model!

One of the next considerations concerns who to contact at the postsecondary institution. Who is your contact at the undergraduate level? This, of course, varies tremendously from school to school and from year to year. We must know where to look in order to make such valuable assistance available to the potential applicant. Would we contact an EOP office, a Placement Center, or other counseling offices? Are there any "active" student groups on campus, i.e., predental clubs, Black Student Health Alliance, Black Student Union, MECHA, and Chicanos in Health Education. Are there minority faculty in Chicano Studies, Black Studies, and Native American Studies programs?

E. James Lopez, Executive Director, National Chicano Health Organization, leading discussion.

One of the best contact resources is the undergraduate campus recruiter who may remember that "Joe Jones" or "Jose Garcia" demonstrated interest in premed or predent when he was applying to undergraduate school. A good way to establish these contacts is to have alumni return to their respective undergraduate campuses to recruit. They may still have former classmates and teachers who in turn have contact with predental students.

Determining when and where to go on a campus can also be a problem. At the high school level, it is often possible to speak before career orientation and guidance classes. At the undergraduate level, where many students have classes on alternate days, the opportunity to speak to them lessens. These are obstacles that can be overcome with the use of good publicity, but even good publicity does not alway prove effective on weekends when so many conflicting events

occur. I might add that experience has taught us that an information table or a one-hour noon-time "brown bag" lunch session is more effective than an all-day session.

Now that we have our audience, presumably undergraduates, what do we say to them and what information do we request from them? Just as in high school recruitment, *honesty is the best policy!* Do not misinform or deny factual information. If a student has a 2.01 science grade-point average his chances of being admitted to dental school are minimal. There is, however, a chance of being admitted, and the applicant should be told so.

It is of paramount importance to convey to the applicant the time frame for application and admissions procedures. It is not possible to apply to dental school in June and start classes in September of the *same year*. A year-long process is necessary just to take the required entrance examinations and to submit national application service forms. Deadline dates are placed on submission of individual school applicants, grade transcripts, and the taking of manual dexterity tests.

This leads to another important point: do not overwhelm the applicant with verbal facts. Taking written information to leave with the applicants makes it easier for them to recall testing dates and sites, registration deadlines, and the like.

When eliciting information from the applicant, it is wise to find out the full name, address on campus, telephone numbers at school, a permanent phone number (of parents), undergraduate major, anticipated year of graduation, and field of interest. Do not ask questions about age, sex, marital status, national origin, or religious preference.

Experience has taught us the importance of who speaks to whom. Last spring, a Black dental student was sent on a recruitment trip to UC Irvine where he spoke to a group of Asian females. Had the publicity and other arrangements been more carefully coordinated between the undergraduate campus and our office, we would have sent an Asian female instead. At least, that is what we attempt and prefer to do.

Once names, addresses, and telephone numbers have been collected, what is done with them? How can we provide follow-up to these prospective applicants? It is important to keep a list of all minority students who are prospective applicants, including freshmen, sophomores, juniors, and seniors. Those of us in our program currently are recruiting for the fall 1977. Simultaneously, we contact freshman, sophomore, and junior students to let them know we are still around. We urge them to continue working toward their goal of becoming health professionals and we provide a *trusted* source of contact within the university.

The health professional who is out in the world serving his community can claim rewards of deep personal fulfillment. Such fulfillment comes from seeing the smile of a child whose toothache has been painlessly relieved, from the gratitude of an elderly patient with a new set of dentures that allow him to eat again, or from the hearty "Thank you!" of the job seeker with the "missing front tooth" who is then able to find employment because she can face people again and smile.

Renovating Models on Retention: Academic Preparation— A Key to Success

Bobbie Ross, M.S.
Project Director U-MED Program
Upstate Medical Center, State University of New York

Although I am relatively new to the health professions, I am not new to the problems of minority education — the fact that those students are not being well taught. When I started working with medical students last year, I found that there were the same kinds of problems that high school students from economically disadvantaged areas encounter, just at a different level. Now I know there are a number of factors that influence the success of students: financial aid problems and/or emotional problems that add to the burdens that reflect on the level of student performance.

However, I am primarily concerned with the deprivation of academic educational preparation. Because of this lack of preparation, which is often due to such things as long-term matriculation at noncompetitive schools, I believe there must be a three-pronged approach to retention. We cannot work only with students presently enrolled — even though they should have our highest priority — but we must also work with undergraduate students and students on the high school level to ensure better preparation.

My own particular interest is setting up some kind of long-range liaison between students and schools so that we can better prepare the students. We must give them information about the skills necessary to succeed in medical school, and see if there is any way that these can be incorporated either into what is presently being taught or into new methods. We are concerned about working with incoming freshmen, sophomores, and juniors.

In trying to find ways to emphasize the necessary courses and the proper sequencing of courses, we find that many people have taken the MCAT exams before they have had necessary science courses. Specific skills that need special emphasis — communication skills (language, both oral and written), and familiarity with scientific terminology, biological and chemical symbols, problem-solving ability, analytical thinking, test taking, study skills — need different approaches to various kinds of materials. We must realize that it is not enough just to have the bare minimum, that there are some materials that need more in-depth familiarity than others. We also need to give our students survival skills to deal with a racist environment with which they are sometimes confronted.

We are establishing the communication and getting the students to focus their energies and make them realize the importance of being better prepared, because this eventually helps to reduce greatly the problem of retention once they are in medical school. One of the things I find most helpful in the students I am working with is a willingness to accept help for a realistic self-evaluation of a deficiency. Those students with academic weaknesses particularly need contact with other people to make certain that they keep their perspective on an even keel with everyone else.

I am involved with a specific retention activity involving a Growth Anatomy course given in the summer; it is attended by more than 90 percent of the minority students presently enrolled in the first-year class. Every effort has been made by the chairman,

faculty, and administration to keep the content and quality identical to that of the course taught during the regular year. Having successfully completed this course and entering the academic year with advanced standing has added greatly to the self-confidence of the students. Recently, we have developed a booklet on anatomical reference terms that we will give to the students so they can have some familiarity with the terminology before they enter in the summer. During the Growth Anatomy course, we teach the study techniques of memorization, recall, test taking, and lab preparation. The time this participation in the summer program frees up is used to teach study techniques on an individual basis in conjunction with the teaching of biochemistry, which is the next course taught. The subject matter of biochemistry lends itself to the full range of all the study techniques, particularly because only new material that is to be learned is covered, and there is no transfer of material or information.

The study techniques are designed to improve learning ability and save time, which increases student efficiency and retention. We work not only with students who definitely need our help, but also with others who can learn to be more efficient with their time. The theory of each technique can be learned in 30 minutes or less. Taking one technique at a time, students put in a minimum of 30 minutes a day for a week practicing it on lecture notes or any other material they have to learn; all techniques can usually be mastered in 10 one-hour conferences. It is the students' responsibility to use that technique each night with whatever they are working on.

Asst. Professor John Alvarez responding to question from the floor.

Last summer we set up a mini-course teaching mathematical concepts necessary for the mastery of the basic science courses to help students better understand the biological phenomena they study during their basic science years: such things as reading values from graphs, statistics, linear logarithms, and power functions. Student exam performance is monitored, and a critique is held to assist students in areas giving them difficulty. For many students it is not a lack of information that causes them to do poorly on exams, but rather a reading problem. You look for patterns and this kind of thing in their work. Some faculty are very cooperative in returning exams for exam analysis, but unfortunately others are not. Faculty members also have made available time for weekly review sessions with students — although I must emphasize that the student has to be familiar with the material before a review session.

We have programmed self-instructional materials that were developed by the first- and second-year student consortium of universities called the Health Science Consortium; the materials are housed at Duke University. We found that the materials vary in quality because there are 38 medical schools involved and many people from all over are involved in developing the materials. So we had to evaluate them to ascertain how useful they might be and at what times they might best be used.

We also have set up a systematic review for the medical boards, with the students meeting once a week for review in a particular discipline each week. They go through materials and decide what they need help with. Then we get someone to help them from that discipline. We prepare specific approaches for each discipline before the student begins that discipline.

It is through means and methods such as the ones I have outlined that we hope to help our medical students from disadvantaged educational backgrounds achieve the same successes as the better educated majority students.

Renovating Models on Retention: Developing Skills Programs and Support Services

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Support Services Coordinator
Office of Minority Student Affairs, University of Colorado Medical Center

At the University of Colorado Medical School, we have tried to implement as many study skill workshop programs as possible to allow an open door-type policy. All students may participate, majority as well as minority. We believe that approach is the most important thing we have been able to maintain. Programs that the Minority Student Affairs Office has for retention are open not only to minority students (with primary emphasis on them) but we also accommodate as many majority students as is feasible.

In addition, we also have tutorial services. We expect firm commitment from the tutors. We try to pay a salary equivalent to a person of graduate school ranking, $6 per hour. By paying this salary, we feel we draw good students. We work with the students on what we call contract system. That is, tutorial session volunteers agree to a contract I have devised. It outlines three basic responsibilities: (1) that the tutor be on time, (2) that the student be on time, and (3) that both student and tutor be prepared for each session. The tutor maintains logs of each tutorial session and turns them in regularly for evaluation. Should we find a discrepancy or if there is a problem of the tutor keeping his time, there is a penalty for it.

Because our office provides this service for the schools of nursing and dentistry, what we have is centralized tutoring at the University of Colorado. Thus, in a sense, minority affairs has control over the entire tutoring system at the Medical Center. Our prime goal is in helping all students who are educationally disadvantaged in the sense that they rank in the lower third of their class. We maintain what we call an Early Warning System at the University of Colorado Medical School. This test, designed and requested by the students to give them an idea of where they stand immediately, is given two weeks into the quarter. It designates a possible warning that a student may have problems, personal or academic. We want to know, we want to extend our help. Should the student accept it, then we assist him right away in obtaining a tutor.

Students can choose an upperclassman or even a classmate for tutoring. We have discovered that many of our freshman students have master's degrees in basic

Various ethnic minority views shared were valuable resources.

science fields, and we have utilized them. We let students choose their own tutors, and we try to have tutors available as soon as students come to us for help.

Some students tend to procrastinate when they are in trouble. It happens in many schools so we try to get the student involved with a tutor as soon as possible. We leave the responsibility for making the arrangements up to the student; it is his responsibility.

When we choose the tutors, we go through short training sessions. We need students who can teach the survival instinct. What we are looking for is their ability to relate to the student, their ability to teach the student how to relate to faculty, and how to surmount racism. We put a lot of responsibility on the tutors, and they respond in kind by trying to follow through.

Because you cannot really implement complete changes, change behavior or change a whole method of study skills and notetaking immediately, all you can hope to do is advise, give ideas, and direct students to texts that might be able to help them.

The next step in working with the students is trying to develop writing skills for many of our students. These are important in writing briefs, nursing histories, and medical reports. There are many qualified resource people within our community out of work who we have sought for this task. We reteach the basics of paragraph development and research.

Last is our summer program: we try to implement all these things in our summer programs at the nursing school, the graduate nursing school, and the medical school. The summer programs for the medical students are taught on an "organism approach," in other words, an organ. Last year it was the heart. We taught 10 weeks of the biochemistry, physiology, and anatomy of the heart, and a bit about biometrics and statistics related to heart incidents. We also included vocabulary-building skills. The technique used was that if a student encountered an unknown word, he wrote it on a card. Then the students were tested weekly to make sure that they understood the words.

Our future goal is to develop a reading program based on the reading texts used at the medical and nursing schools. This is very important because of the students' limited free time. They do not have time to get as deeply involved with the reading programs as they should. Thus, we are trying to develop a reading program geared to particular texts they are using rather than supplemental ones.

Motivating Faculty and Administration to Meet Minority Student Needs

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The question of motivating faculty and administration to meet student needs is riddled with a basic paradox. Simply stated, most medical school faculty are hired on the basis of their research expertise or promise thereof, whereas their major funding source is the state or private organization that pays them to teach. The majority of medical faculty I know have no formal education in teaching. Their strongest suit is research. It is, in my experience, a very exciting, and a challenging career. To use a popular expression, there is a "positive stroke" for doing research. To those of us who wish to influence the faculty, we need to know what they are most sensitive about. Again, simply put, it is factors like promotion, financial stability, tenure, and administrative duties.

Until the advent of minority programs, most faculty were busy teaching highly qualified, motivated, ambitious students. Enter minority students, who are also motivated and ambitious but educationally disadvantaged. They encountered a faculty and student body who initially felt that they were there because of federal pressure (which is true). Before federal programs began, many schools were not aware of this aspect of our society. Suddenly, administrators felt the pressure to admit minority students. The faculty also felt this transmitted pressure and both have begun to raise questions regarding academic standards, protecting the patient, and the like. To improve their program for minorities, the faculty are asked to define their educational objectives so that specific programs can be designed to academically support these students. Most faculty cannot or will not do this because they believe it is "spoon-feeding the students" and "the entire approach is not really teaching students to think."

I feel that a large part of this reaction is due to the fact that faculty per se were asked to contribute in a way that really was not in their legitimate area of expertise — education. I am fascinated by the fact that, in the state of Minnesota, I cannot teach in high school because I do not have the necessary courses in education. Since I found this out, I have been able to understand the reaction of faculty toward these programs. In my estimation, the faculty were not adequately prepared for the task nor was the task specifically spelled out for the faculty. Thus, we have to educate medical school faculty.

Most medical school programs dealing with minorities are experiencing a certain amount of rough sledding. Reverse discrimination is beginning to rear its multifaceted head, claiming that it is unconstitutional for minority students who are not well prepared to take places from qualified nonminority students. Those who propose that minority students offer a blend of what is societally and medically needed and therefore they should belong in medical school are hoping that a significant population of minority students will return to their respective barrios, ghettos, or reservations. Reverse discrimination is by no means an easy problem to solve, much less to identify. Who is the discriminator and who is being discriminated against? My basic position on this is that there has been enough discrimination against racial minorities and women so that we have to catch up to the nonminority groups.

Administrators, good ones, are aware of the global mission of their school and as such are also looking for various effective ways to retain minority students in school. They do see the societal mission of the school. I suppose that one of the basic differences I have found between sympathetic administrators and those who are not so is being aware of being part of a large societal system and having the university attempt to adjust to these changes. Whereas others, known as the misguided administrators, feel that they are the universe and everything must fit into their small-world microcosm. Both kinds can be motivated.

Societally sensitive faculty have also been involved in minority programs; however, there is a critical difference between the faculty and the administrator. The faculty will not receive any accolades or promotion from their chairman if research is not forthcoming. An aggressive chairman or dean wants grants on which to build. In my limited experience, it is easier to talk to an administrator concerning some aspect of a minority program than it is to talk to a researcher-teacher faculty, primarily because their points of view are different. Young faculty are usually more societally conscious than others but they are still vulnerable because they do not have tenure. Faculty who have tenure are usually constantly trying to do research, so to think that they will spend more time teaching students is not too realistic.

Therefore, I hope that I have mentioned some of the major problems in this area: faculty teach and do research, but they are promoted for research. Administrators are either good or poor as they see the mission of the school. How does one motivate their faculty and administrators to get involved in minority programs in a significant way, and how would they specifically work on retention programs? We need both long-term and short-term approaches. The short-term approach is to use the major expertise of the faculty to our advantage. For those faculty who are working with minority students, financial support should be available for running some aspect of their research (such as a technician, a piece of equipment, supplies, etc.). The faculty who get this extra support should then be willing to offer tutorial sessions to students and extra time to discuss tests, redesign their area of the curriculum, design innovative ways of presenting basic science material, etc. We want something — they do too — so let's deal! This approach is primarily for the present, to get disadvantaged students through the curriculum. This short-term approach, I feel, is vitally necessary but it is a double-edged sword.

It is urgent that we get minority students through the basic sciences since we cannot afford to wait five years until all minorities are qualified. The risk we run is that we sometimes make mistakes with accepting certain minority students who do not make it, but we do that with majority applicants as well. Tutoring and special session are important, but many minority students feel that these kinds of programs signal them out as minority students. Further, faculty feel that they are not really getting the material — and finally to add insult to injury, their peers, when they are out practicing, will wonder if they are as qualified as they are. We all know students who have had low MCAT and GPAs and have done well in medical school. These students, in my estimation, were the real superstars, but they had motivation. However, I sometimes wonder how many did not make it.

The question of retention in medical schools is based on the premise that the minority medical student has to have some form of remedial program to remain in medical school. However, not all medical schools are alike in curriculum, in that some offer (1) a coordinated system approach so that all students must take the entire curriculum at once — physiology, biochemistry, and anatomy are taught at the same time; (2) others (a typical old-time approach) in a discipline presented their information seemingly independent of what goes before or after it; (3) others teach a combination of either of the above and allow a certain amount of individualized education to take place by computers. Therefore, educationally disadvantaged students must move into these varied systems and learn how to survive. However, the major responsibility for allowing students to meet the stated educational objectives of the school must be a two-way street between faculty and students. Students must have a certain amount of intelligence, but in my opinion, motivation to succeed is paramount. Faculty must be supportive of students and motivated to do so, but in most cases there are a number of stumbling blocks to avoid before such a process can begin to occur in the minds of the faculty.

1. The faculty should be consulted as to the scope of the minority program. Why is it there? Attempting to have faculty become involved by saying that federal pressure is the major reason for these programs does nothing for instilling a positive mental impression concerning the program. Most faculty in medical school are aware of the seemingly fickleness of federal programs, and if federal pressure is the only reason to have a program to recruit and retain minority students, it will not sell. A more positive approach is to present the statistics on health care delivery or the lack of it in the ghetto, the low number of minority physicians, etc.
2. The faculty should be constantly exposed to the culture of the disadvantaged students. We are social animals. If there are minorities

around, we will listen. Most medical school faculty have no real education concerning Blacks, Chicanos, Indians, and other minorities, and as such cannot see why such programs are needed. In my personal experience, most faculty are receptive to seminars that deal with minorities. Whether they make a commitment to work with minorities as a high-priority item is another question. However, without some exposure, the faculty will not be sensitive to cultural differences of students. There will be some faculty who will never be able to comprehend why culturally different people reject becoming completely acculturated. This, I feel, particularly applies to Indian people.
3. Assuming that the faculty have agreed to work with disadvantaged students, the question remains as to the kind of minority program. As most people know, there has been a variety of minority programs: some concentrating at the high school level, some concentrating at the college level, others at the medical school level, and some encouraging all three levels.

My third point has two parts to it: minority and nonminority faculty. In either case, if faculty are going to act as role models in terms of teaching and tutorial programs, some acknowledgment of this effort should be made regarding promotion and tenure. Such acknowledgment is not to be shown too often since promotion and tenure will be made on research publications and scholarly activity. It has always struck me as ironical that in medical school the faculty are paid to teach and yet promotion is based on tenure. It could be extremely difficult to have faculty commit themselves to educational programs if, in the process, they jeopardize their careers.

One way to handle the dilemma would be to have minority faculty spearhead such programs. But we are not producing enough minority faculty and we have to work with the nonminority faculty.

I am sure that there are some who feel professional schools should have more of a commitment to teaching, but that is not the system. Medical school faculty talk about research at meetings, not about teaching programs, and I feel that this research emphasis philosophy is the way toward the long-term stability of getting educationally disadvantaged students into schools.

Nowhere is it easier to get to know the faculty than in their labs. What I am proposing is that educationally disadvantaged students spend time during their undergraduate years working as researchers in various labs, with the emphasis being in those labs that are biomedically oriented. This would also expose faculty to the social aspects of minority students.

Some might respond, "That approach might be good if we minorities have four to five years to wait. What about now — and working with faculty?" or, "That might be a good idea, but we don't want all minority students to become Ph.D.s in Physiology."

To answer the first of these points; I feel that the "honeymoon period" for disadvantaged students is

over. Professional schools will continue to be more guarded in terms of entrance criteria. If we wish to help minority students who are educationally disadvantaged, I do not feel positive that faculty will want to offer special courses, tutorial systems or not. Federal support for such programs is limited. To be more direct, I feel it is now that administrators should be more supportive. Funds should be available so that preprofessional courses, tutorial systems, and a flexible curriculum are available.

My personal opinion, based on experience working with Indian and Chicano students primarily, is that accepting educationally disadvantaged students does a disfavor to both the students and building good rapport with faculty. I am also aware that there is a question of whether there is any correlation between doing well in the basic sciences and in the clinical sciences. However, the present system is such that, for the foreseeable future, there will be a strong emphasis in the basic sciences. We have to get our students through these courses and I believe that the best way to do that is working in the medical school.

The real solution to this problem, I believe, must be that the minority student and faculty work together in the research lab, whether it be clinical science or basic science. In this environment, both groups can learn about each other. If properly conducted, the student can learn an extensive amount of material in a number of areas. A student exposed to a cardiovascular physiologist can be exposed to the following disciplines: biochemistry, anatomy, physiology, surgery, and pharmacology, to mention a few.

The best example of this kind of approach is where students are involved in such projects in their undergraduate years. Because the medical school faculty would take undergraduate students and work with them in their labs, theoretically the students would be motivated to doing well because they would be working with the faculty and they could see the relevance of physics, math, and chemistry, to the health sciences. In addition, we will be offering the student a position in medical school once he enters undergraduate level and maintains a certain average.

I have approached this problem by believing that faculty are the people who need to be educated. Once they are, there are a large number who will help. If there are ways to reward this contribution by faculty the same research is rewarded, then possibly medical schools will begin to be *educational* as well as research institutions.

Summer Programs: A Preprofessional Approach

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My approach to the retention of students is different than that of others at this conference because most of my efforts in retention occur on the preprofessional level. I want to mention some items that I think should be intrinsic within any retention program.

As has been said, "the honeymoon is about over" for minorities. We are highly contingent upon federal funds. Five to six years ago, when federal monies became available for minorities, schools suddenly became interested in minority programs. Consequently, I believe as the money varnishes so will the social consciousness and concern on the part of these schools.

Thus we must think of alternatives — what is going to happen to us, to our jobs, and to the students in our programs. We will have to develop a much more deeply engrained consciousness on the part of the faculty and administrators because schools are going to have to assume the financing of these programs or will have to seek additional funds outside the federal government; this will be a very crucial time.

Most of the discussion on retention, thus far, has involved academic retention. Those who deal with students, however, know that they have problems other than academic ones. In fact, when I first became involved in minority admissions and recruitment retention, it would bother me greatly when people talked about minorities and tutorial programs in the same breath, as if all minorities needed or required some tutorial assistance.

That is true in some respects, for many of us in our high school and/or undergraduate education were not fortunate enough to receive the benefits of some of the better schools — schools where the traditional or majority students come from. But academic retention involves only one phase of retention. We also must think in terms of financial assistance, and it seems absurd that the federal government will disburse money for all types of programs and conferences yet cut out money for direct support to students attending schools of health professions.

We must also consider the social and adjustment problems of students, especially those of students coming from smaller colleges who enter large, predominantly white universities. Many times they have no one with whom they can discuss these problems. They cannot approach the faculty for various reasons. Often there is no minority faculty around.

When I speak of retention, I am not thinking of a bandage-type of program. I am not saying that the student is in trouble, so he should be involved in a retention program. Instead, I am thinking of a program that helps the student to cope with the system, to graduate in his chosen discipline, and to become a skilled professional within the community.

We try to utilize retention maneuvers from the first day. We try to reinforce the academic learning of the student. But more important, we also try to reach the student prior to the professional curriculum; that is, we go to the high school level and start working on motivation because, unless the student is motivated, he will have difficulty. I believe motivation is the key to any retention program. It is twofold and involves the

student and the person who is attempting to educate the student. Trying to sensitize the faculty and administration has been a struggle of mine over the past couple of years.

If a student is brought into an academic environment during the summer, there are several things that must be done.

1. If the student is going to be in a program for the entire summer, we are removing him from the work force. So I believe that any retention program should provide the student with some sort of stipend that would not necessarily replace what the student could make during the summer, but would at least not make school a handicap for the student.

2. I feel that provision of academic credit during the summer program should be an intrinsic part of any summer program. It is easier to interest a student in a program primarily for academic reinforcement purposes if you provide an incentive.

3. If travel is involved, travel monies should also be paid. There are ways of getting funding outside HEW. Other federal, state, and local programs will provide money to assist a summer retention program during the summer.

Concerning the scope of such a program: what are we trying to do and what is the target population? We have attempted to set our definition to include the ethnic or colored minorities, the Chicanos, Blacks, and American Indians. To increase our funding chances, we also extended our definition to include veterans, women, and low-income whites. Yet when viewing our program over a three-year period, we see that we have not really attracted what I would call the hard-core, inner-city disadvantaged minorities. Most of our students come from well-integrated families having both parents living together, with families of relatively small size. The students attend high schools that are well mixed and have fairly good basic counseling staffs and courses.

When our funding proposal was written, we did not want to include that academically successful student. We feel that these students have enough chances already: they are pushed by counselors, by professors, or by teachers. Also, they have enough initiative so that between all these variables they will find a way to advance. What we wanted was the average student who needed a little help and/or encouragement. Thus we set grade-point levels. On our college program we set a 3.3-grade-point level as a ceiling.

Our program at Indiana is a multi-phasic program, basically in two parts. There is a high school program of two weeks and a college program of six weeks. Only the college program offers academic credit — four hours. The two programs are similar in that we try to introduce these students to nontraditional alternatives within the health professions. We do not steer students into a given health profession. Even though the School of Optometry sponsors the program, we bring in representatives from various allied professions, and the various allied supportive health professions (because not all students can or want to be physicians or dentists). And often, many students, once they observe a health profession, say medicine for instance, find out that the Dr. Welby-type of charisma is really not for them. They want something else. So we try to save time and money by providing in-depth counseling, academic counseling, and financial counseling (we do financial profiles for these students because many of them are naive when it comes to securing financial aid).

We bring in various clinical specialties; we have field trips and go into hospitals, clinical offices, and laboratories, and we try to be a role model for these students. We want to give them the opportunity to identify with working minority health professionals.

Small discussion groups helped promote understanding.

This year we expect to develop a preceptorship where we will try to link a given student with a given health professional or clinical specialty of their choice. For many of these students, their self-concept or self-identification is lacking. They are interested in the health professions, but they really are not sure if they can be successful. Many do not get support at home. So we try to be there at any stage in their career development, when they can come to us for assistance, even after they have finished the program.

There is didactic involvement. The college students are in the classroom about four hours per day. We try to give the students an impression of a health professional curriculum — what it is like to be in a health professional school. So we offer them such courses as neuroanatomy, physiology, physics, and psychology. We try to gauge the courses to the types of students that we enroll for a particular summer, so the courses change on a year-to-year basis.

Along with didactic involvement is experimental involvement. Students work in laboratories in a hands-on type of experience. It allows them to discuss cross-cultural barriers. I have found that it is good to have Black students talk to Chicano students about their respective problems. In doing so, they realize that certain problems are not peculiar to them. This gives them a feeling of oneness in that there are other people who are subject to some of the same situations and that perhaps, collectively, they can pool their resources and assist each other in coping with the system.

Following the summer program, we attempt a follow-up; we try to maintain as much contact as possible. We even assist students in making application to professional schools. In fact, within the past three years, we have assisted seven students' entrances into a health professional school directly following attendance at the institute. This was a more cost-effective and time-effective situation as far as the student was concerned.

We also work with an association called Indiana Health Careers (IHC), which does some of the same things we are doing within the state of Indiana, but it also assists us in our follow-up. IHC has contacts within the various health professions and can visit high schools and colleges more often than we can. Its personnel talks to counselors, to administrators, and to faculty more often than we can. So we utilize the resourcefulness of that association to assist us.

Each year we have an evaluation of our program by the students and the faculty. We want the students to tell us what is wrong with the program, what its good points are, what they need, and what they want. Then we try to incorporate this advice into future programs. Soon, students from our high school summer program will be entering our college program; this will give us a second shot at them.

To judge the effectiveness of such a plan as ours is difficult because it is not necessarily an immediate success story. When we deal with a college sophomore, it may be one to three years later before he or she applies to a health professional school. Nevertheless, I feel that any retention program can be a success if it is directly proportional to the motivation of its students (I must state I equate motivation with maturity). I also feel that success is directly proportional to the social awareness of a school's administration — an awareness so that the administration is concerned not only with federal dollars but also with increasing the distribution of minorities within the health professions. Equally important, there must be facuity compliance. If the faculty are not deeply involved in the program, there will be problems. Also, we must have minority faculty within the health professions so the students have someone to identify with and discuss problems with. Within the School of Optometry at Indiana University, I am always available to my students.

Last, there is the problem of financial assistance. As we all know, the government is really cutting back. Thus, until we come up with alternatives to increase minority health professional involvement within various aspects of the community — in the innercities and core areas — it is my impression that students in the health professions will be there directly as a result of who they know and how much money they have. Some schools did not want our programs from the start. With federal retrenchment, now they have the excuse to abandon the programs because they are too expensive. We need, then, to begin thinking about what is going to happen when the water is cut off, because it could be a very thirsty spell for many of us.

Government Funding Outlook

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I represent El Congresso, a lobby in Washington, D.C., which lobbies for Spanish-speaking people in the United States. There are many questions about what kinds of funds are available for minority programs. Unless we become active in the legislative process, however, there will not be any funds. To get funds, we have to become involved in the lobbying process — we must organize and be recognized nationally. Only then can we show Washington that we have some clout.

Who do you lobby? — The Administration (White House staff members), congressmen, bureaucrats, congressional staff members. People who are at the state level listen to group representatives. You can have more impact when you are representing a group.

Once you get involved with lobbying process, you get the kind of wording that you want into the legislation. Then you choose a format. What part of the legislation are you concerned about? You should be concerned about the Health Resources Administration, the Office of Education, the Minority Biomedical Support (MBS) program, SHCOG grants, the National Health Service Corps, plus the language that is in the legislation, the financial aid, and Public Health Service grants. All of these programs are presently before the congress. Now is the time to act. Once you get the legislation that you want, you must follow that legislation to the appropriations committee. Because they authorize the money, you have got to be there to be sure that the money is going where you want it to go.

This is an election year. What is the Chicano strategy? The Black strategy? The Indian strategy? SHCOG is going to be put in a block grants program with 16 others competing for $120 million. If that figure is averaged out, that puts SHCOG back at about the 1972 level. The Minority Biomedical Support program presently receives $7 million. Inflation alone requires that this program — one that we very much need — should get $13 million. In other words, the effectiveness of that $7 million has been reduced by almost half in just 3 years. What is going to happen a couple of years from now when people coming through the program want to go on to some graduate school program? There will be no money to support them. That is why, as lobbyists, you must be there. There is a fairly active group within the association of MBS programs, but more effort is needed from them.

What are you doing with your funds? Even though you have to produce because you have a contract, you should also think about some lobbying activities. To continue, all programs have to be renewed every couple of years, and you must to keep track of them. That means a long-term process of continued active involvement — on all levels.

Grant Writing: A Question of Survival

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An interaction of three critical units in government that determine *who gets what* is popularly known as the Golden Triangle or the Iron Triangle. It is the basis for what are called categorical programs which, in the last few years, have been the target for change. This is because, no matter what the policies may be, the categorical programs grow and defy efforts to terminate them.

The three units of the Golden Triangle are:

1. The first is a representative or a standing committee in the legislative body that has a special interest in a well-defined area; for example, concern about who gets what in health manpower. So far as the legislative body is concerned, one would have to identify both representatives and standing committees that handle health manpower policy. Those standing committees would have the concern of the legislative mandate; they usually are assisted by a committee staff and are in close touch with the other parts of the Golden Triangle. One also needs to identify committee staff as well as the representatives' staff who are pleased to get letters, telegrams, and position papers, especially when they are written to make the legislature aware of the special concerns.

2. The second part of the Golden Triangle resides within the unit that has the authority to administer that particular piece of legislation. The individuals who have responsibility of administering the various parts of health manpower legislation have been identified and are well known.

3. The third part of the Golden Triangle is a constituency group, a group that continues to promote what it considers critical issues. Again, there is interaction between the constituency and heads of administrative units.

In terms of "who gets what" in health manpower programs, it is important to know the key persons and to understand the interaction of the three units of the Golden Triangle. Many people wonder how, for example, programs exist when there is no visible constituency. For the most part, it is because of the good will of some of the representatives and probably others with guilt feelings in the constituency organizations that do not represent you. The question then becomes: How can you continue to exist without a visible constituency group that represents you and your interests and the kinds of concerns that you have? Whether it is right or wrong, needed or not, the point is that a visible constituency is needed; otherwise, it is difficult to get attention. The establishment will say that no one needs it, there is no interest in it, and so they can forget about it because no one cares.

Another important occurrence that has happened in the last three years is the so-called pendulum change. During the decade of the 1960's, the pendulum moved from the biomedical arena into the community arena, in some instances. There were people talking about community medicine, community nursing, and community psychiatry. Thus, many people were going out and doing things, and people talked about community medicine. In the last few years, however, the pendulum has moved back to the biomedical arena — the classi-

cal interest of medical schools. For example, people in the community are now going back to the old classical approaches of psychotherapy and identification with the old names in the era of classical psychiatry. So again, you are caught up doing things in the community: talking about social medicine and social aspects. "They" are likely not to pay any attention to you unless your representatives at least express themselves.

My other point has to do with the manpower concept. This concept is just beginning to make itself felt in the bureaucracy. For example, for the last 25 years, the mental health field has been concerned only about training, which is only one aspect of manpower, and increasing the number of psychiatrists or other mental health professionals. There has been very little interest in licensing, certification, recruitment, retention, curriculum, or utilization. Whatever you want to call these things, they are all important parts of the manpower approach to the problem. Your interest must be thought through in a way that comprises the kinds of interests that you have. People have mentioned diminishing funds, implying that the "honeymoon" is over, and other similar terms. What they are really saying is that they are ignoring those they claim to serve or to care for. If they do that, then what are the funding agencies and representatives going to think about it? For example, this community suffers daily. When no one does anything about it, it suffers even more. But when the people know that someone cares and is trying to do something about their situation, then there is at least a feeling of hope. The people feel that something can happen. But if their representatives abandon them, what is there to strive for, to live for, to hope for?

You need to become acquainted with the political process. Those running for office become involved in the campaign, assisting and helping them and getting to know their local staff. Representatives have staff that do casework and answer thousands of letters. Some of the representatives place much value on this service they provide to their constituency because they feel that it is one way of being useful. Until recently, only funds and model cities funds were supposed to be federal funds for poor people or people in need, which they said was different from the funds universities receive. They feel the latter are not welfare, that they are different. But it is all federal tax money, regardless of whether it goes for a poverty program such as the Community Action Program (CAP) or to a university. Thus there is reason to be concerned about it and to do something about influencing the way the funds are utilized, thus you should not be apologetic about mentioning it up to your university president or medical school dean.

The Comprehensive Health Manpower Act of 1971 provides for capitation grants, start-up grants, conversion grants, special project grants, financial distress grants, health manpower initiative awards, student loans, student scholarships, family medicine grants, teacher training grants, construction of teaching facilities grants, grants for computer technology programs, and national advisory councils. They get more funds from other federal agencies and it is just like poverty funds and CAP funds. It comes from the U.S. Treasury so you should not be apologetic about trying to influence what they do with those particular monies.

The point about biology-physiology concerns appeared in a March 9, 1976, *New York Times* article about the scope of medical school education. It said that pressures to broaden the scope of education in the nation's medical schools can lead to serious problems for the future of these institutions. Two medical experts who spoke at this meeting yesterday said the primary purpose of the medical schools should be to teach prospective physicians the nature of medicine and disease without delving into social problems. The sources of the pressure stem from economic, social, and educational sectors of society. These sectors tend to blame medical schools for the high cost of health care for the impoverished, the lack of health facilities in urban core areas, and the training of doctors who society now often views as poorly trained to provide the family care that many citizens so vitally need. What they are saying is that it is dangerous to go in that particular direction. Also, they quoted someone else as saying that many of the disciplines and expertise for planning health care programs were not primarily medical, but resided elsewhere in the university. Going back to the biology is important; you cannot really argue against that.

What does grant writing mean? Get to know the staff — by phone or when they come to your community. Visit with them, exchange ideas. Get a copy of the legislation that they must deal with. Prepare a three- to five-page draft, send it to the appropriate staff with a note saying that you would appreciate it if they reviewed it. Give them a couple of weeks, and ask them to send it back for a second go-round. What happens is that many times, especially in this area, you often are perceived as being two or three years behind the times. It is claimed that most of the action is on the East and the West Coasts, but nothing really happens in these areas. What you call unique they probably tired of two years ago. Emphasize the uniqueness of whatever it is you are dealing with in your individual area. In some cases, the staff you are communicating with have never been to your community, and it is important that you provide a historical analysis of what your region is about — its politics, its people, and its resources.

Funding and Foundations Monies Available to Special Admissions Programs

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The firm that I represent, Human Resources Corporation, is a minority-owned research and consulting firm with a multiethnic and multidisciplinary staff. We have completed contracts with county, state, and federal agencies, as well as private foundations, in the fields of education, health services, social services, community organization, transportation, and urban planning. We are now in our sixth year of operation.

HRC's president, Herman Gallegos, is the only Chicano trustee of a major foundation. In the entire country there is only a handful of ethnic minorities serving on major foundation boards. This is one of the reasons why we sought support from the National Science Foundation to examine the work of the private foundations. The focus of our NSF study was on identifying and analyzing public policy issues related to the responsiveness of grant-making charitable foundations to the problems and concerns of Asian Americans, Blacks, Americans of Spanish heritage, and Native Americans in the United States. We discovered that there are some 30,000 foundations in the United States.

Five types of foundations were identified to reflect major distinctive program objectives and the structure of a foundation:

1. *General purpose foundations,* with broad charters, "directed by boards of trustees with wide interests." Most of the larger well-known foundations such as Carnegie, Ford, and Rockefeller are of this type; most operate with professional staffs.
2. *Special purpose foundations,* "which are restricted by charter to a specific field or purpose," and usually reflect the interest of the original donor. The Carnegie Endowment for International Peace is an example. These are usually smaller than the average general purpose foundation.
3. *Company foundations,* created by corporations to facilitate corporate giving as well as conferring financial benefits on the company. The Tax Reform Act of 1969 has made the company foundation a less attractive instrument for corporate gifts.
4. *Family foundations,* established by a living person or persons rather than by bequest. "Their boards usually consist of family members and their immediate associates, and they often serve simply as channels for the personal giving of the founders." These family foundations sometimes expand their purposes and resources to become a general purpose foundation. The Ford Foundation, which began in 1936 with an original endowment of $25,000, is one such example.
5. *Community foundations,* "composites in which gifts or bequests are administered as to principle through the trust departments of qualified local banks; the income, with any authorized portions of principal, is disbursed under control of a distribution committee selected for representative character and knowledge of charitable affairs."

Two general questions are being raised about foundations — their relevance and legitimacy. With pervasive governmental activity in social areas formerly dominated by private charities, what contributions are foundations uniquely equipped to offer American society? What justifies their tax-protected status? How do they relate to today's society? Given current democratic mechanisms to distribute funds in the "public interest," how are foundations, which have an essentially elitist mechanism for accumulating and distributing tax-protected funds for the "collective good," made legitimate?

In defense of relevance, it is argued that foundations can act innovatively, flexibly, efficiently, and independently. Legitimacy is based on the traditional value placed on pluralism, diversity, and the idea of voluntarism and private initiative.

Foundations do not lack structural restraints, but they are relatively and uniquely free from pressures facing government and operating agencies. A foundation does not need to raise money for internal support; to satisfy "voters, customers, or advertisers"; to fear failure; or to be obligated to duplicate success. It may tread in controversial areas without prior approval and (within boundaries) without adverse consequences. Public criticism to which foundations are subjected represents a different order of constraint. It is the difference between "having to avoid activities that could trigger widespread opposition" and "having to earn the active and continuing support of outside constituencies to remain in existence."

Our study indicates that the private charitable foundations have been largely insulated from the broad-reaching public debate accompanying the spate of recent inquiries into American social institutions. Though numerous and, in some cases, quite influential, generally they have not been systematically scrutinized for programs, functions, and relevance to pressing issues of American life. In particular, foundations have rarely been examined as to their responsiveness to the concerns of minority groups.

In the last few decades, as the federal government has taken over an increasing share of the philanthropic burden, and as new social movements have emerged, the traditional functions and statuses of foundations have been questioned. Foundations enjoy broad tax privileges that only recently have been partially restricted. Foundations must deserve these privileges by acting in the interest of the entire society — especially in response to those who need their help most.

Foundations take no cues from any external political consensus. They never need worry about running for re-election. In theory, they should be among the most flexible and innovative agents for social progress. Minority groups, therefore, should receive *at least* a proportional share of foundation largesse. But this is hardly the case. The statistics are clear and compelling:

- Americans of Spanish heritage account for 5 percent of the total population. According to our research based on Foundation Center data, from 1972 through March 1974, Spanish groups received less than 0.8 percent of all (tabulated) funds disbursed in 1972-1973 by American foundations. Of the 217 grants made to these minority groups, only 39 percent went to agencies controlled by individuals of Spanish heritage populations. The Northeast received proportionately more funds from more sources than did the Spanish populations heavily concentrated in the West and Southwest.
- Americans of Asian descent account for 0.6 percent of the total national population. Foundation Center data analyzed by us indicates that, from 1972 through August 1974, Asian groups received 0.1 percent of the total from foundations for 1972-1973. Further, only 22 percent of this tiny share was awarded to agencies run by members of the minority group. Most of the funds went to Chinese organizations in the Northeast. The West, with 57 percent of the Chinese American population, received only 31 percent of the funds. Other Asian groups — Japanese, Korean, and Filipino — were virtually ignored.
- Afro-Americans comprise 11 percent of the population. During 1970-1971, in the welfare category, less than 5 percent of the child welfare funds went to Blacks, and only 0.5 percent to Black-controlled agencies; of grants to youth programs, only 1 percent went to agencies run by Blacks; of grants to colleges, only 6 percent went to Black institutions; of grants for assisting the aged, only 3 percent was allotted the Black community. These were the findings of an Urban League study.

Peter Chavez, Director of Student Minority Affairs, University of Colorado Medical Center, clarifying representation issue.

Similar patterns can be described for other groups, including women and Native Americans. Minority needs are consistently slighted. Only 75 foundations in the Foundation Center's data base were found in our analysis to have contributed to Spanish heritage and Asian American beneficiaries. When grants are made to minorities, they tend to flow through broker agencies controlled by the majority culture. Regardless of a minority group's distribution within the country, grants are concentrated in the Northeast — the major locus of foundation headquarters in the United States. Studies oriented to Asian — or Spanish-speaking countries are far more heavily subsidized than are studies directed toward domestic Asian — or Spanish-speaking minorities. And finally, foundation money going to minorities is spent primarily on conservative, low-risk projects.

Money flows heavily to educational institutions. Of the $1,234,940 in the data base granted to Asian Americans from 1972 to August 1974, our calculations showed that 55 percent went to education and research. The rest was divided among agencies for health, legal service, technical assistance and development, and welfare. For Spanish heritage groups of a total of $11,557,490, 49 percent went to education. This reflects a general trend. Of all foundation grants from 1962 through 1971, education was the most favored field of service, receiving 33 percent of the total. Health and welfare followed with 14 and 13 percent. In essence, you may be competing with your own institution if you go the foundation route.

The National Medical Foundation, supported by a number of private foundations, gives money to first- and second-year minority medical students. Of the 1973-1974 first-year medical students, 7 percent were Black and 2 percent were Mexican American, Native American, or Puerto Rican. This compares with 3 percent for Blacks and less than 1 percent for others in 1968-1969.

Academic Year	Blacks No.	Blacks %	Mexican Americans	American Indians	Puerto Ricans No.	Puerto Ricans %	Total First-Year Students
1968-1969	266	2.7	20	3	3	0.2	9,863
1969-1970	440	4.2	44	7	10	0.6	10,422
1970-1971	697	6.1	73	11	27	1.0	11,348
1971-1972	882	7.1	118	23	40	1.5	12,361
1972-1973	957	7.0	137	34	44	1.6	13,677
1973-1974	1,019	7.2	174	44	55	1.9	14,044

Both the foundations and the federal government are putting large sums of money into education. Health-related institutions are getting at least their share. Are minorities benefiting proportionately from the public subsidies, even in the public universities? If not, why not?

We think that you in your roles must work within your institutions for greater understanding of the interests and concerns of minorities and for more resources for minority students. As recruitment officers or representatives, you must ask and consider whether you have:

- Firm institutional commitments
- Support within the total institution, including the Board of Regents, faculty, and administration
- Support of a coordinator of development, of public relations, and of alumni relations
- Effective use of alumni volunteers
- An effective and enlightened alumni association
- Sophisticated prospect research and donor relations
- A highly qualified staff and adequate budget
- Fund-raising policy guidelines and priorities
- Well-understood goals and plans
- A written statement defining your personal role in fund-raising effort
- Convincing need of private dollars

It is also important that you know your community and its resources, and how to use them for system change. For example, two of the five trustees of the San Francisco Foundation are appointed by the chancellor of the University of California, Berkeley, and the president of Stanford University. If I were a staff or faculty member of either institution, I would want to make sure that the presiding officer was aware of the interest of minorities on campus in the trustee position on the foundation board and in sympathetic representation of the interests of minorities on that board.

Lack of responsiveness to minorities lies mainly with the foundations themselves. They frequently operate within a constricted compass promulgating social programs that lag behind those put forth by either government or academia. Their boards are ingrown, interlocking, and self-perpetuating. They are dominated by white Ivy League males to the almost total exclusion of women and ethnic minorities. The same is true of

Suggestions for immediate implementation were presented.

the composition of many staffs. Each foundation answer essentially to its own self-appointed trustees. Given these circumstances, it is not surprising that foundations have a history of ignoring minority concerns. Generally they have not made convincing efforts to fully understand them.

The core of our position is that foundations, in claiming to serve the ideal of "public needs" and "the public interest," have not sufficiently provided for the needs and interests of minorities. The question is one of system changes and reallocation of resources.

Insofar as there remains a fundamental disparity between the priorities of minority groups and those of private foundations, it is recommended that minorities give more attention to foundations as institutions and to system-changing possibilities than to formulating technical proposals. Structural alternatives that could enhance the private philanthropic arena for minorities include:

- a matching grant system, currently debated publicly and privately
- a limitation on the life of donor-controlled foundations
- a system of community ascertainment — ascertaining community needs and interests, such as used by the FCC in granting licenses.

Working to bring about changes in the ways in which foundations operate is something in which we should all be involved. You need to join with other minority programs and organizations to work for a more equitable distribution of resources from foundations. One way foundations can be made aware of the problems that you are encountering is through project proposals — requests for funds. While the largest share of funds for minority projects has come from the large foundations such as Ford and Carnegie, there are smaller local and regional foundations that should be approached. The *Foundation Directory*, Edition 5, lists 2,533 foundations by state, describing mission and resources. The annual *Foundation Grants Index* lists grants awarded within seven broad subjects, alphabetically by foundation name. These references should be studied for possible sources of funding, at least on a project basis. The rules for grant applications to foundations are similar to the rules for other grant applications:

1. Do your homework. Know the foundation's areas of interest and objectives and its potential for support.
2. Submit proposals that fall within the foundation's areas of interest and within its means.
3. Discuss your ideas with the foundation before you prepare and submit lengthy proposals. Follow up with a well-thought-out description and justification.
4. If you receive a grant, make regular evaluation and progress reports with a sufficiently detailed accounting of expenditures of foundation funds.

The process of making application with supporting presentations by interested persons of influence will increase the awareness of foundations of needs and interests of minority communities and develop more usable resources for minorities.

The Minority Perspective: Redefining the Minority Health Professional

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The point I want to make involves an incident that happened to me the first year I taught at the university. I had been interested in the area of mental health and its interaction with the law — law and psychiatry, insanity defense, and civil commitment of people. I taught a seminar called psychiatric justice; the class went to the university medical center psychiatric wing and sat in on the civil commitment hearings. We heard a commissioner and two psychiatrists testify that a patient had paranoid schizophrenia. The lawyer defended the woman client in the context of a civil commitment hearing, and then the person was sent to the state mental hospital in Provo, Utah.

After observing the commitment hearings, we talked about it in the classroom the next week. When I asked for students' impressions of the hearing, someone raised his hand and said he felt there might have been a violation of due process, and someone else mentioned that I had said there is a right to notice and that was not administered in this case. One of my Chicano students, who had grown up in Price, Utah (a mining town), said that no one listened to the woman, and when she tried to speak, they put her off or let her talk for just awhile. The lawyer whispered to her but she did not know what he was saying and, at the end of the hearing, they just sentenced her to Provo for an indeterminant sentence and said "good luck." My reaction to my student's reaction was that he was wrong — he was not focusing on what he was supposed to be focusing on, that is, due process, rather than on the person.

I learned something from that student, and I want to share some of the thoughts that I have had since then, having spent 3 years teaching in the law school. Thinking about what happened with my student, Toby, in the session on civil commitment makes me realize what an incredible focus there is on the intellectual in our professional schools. The ancient Greeks approached education from the viewpoint of the whole person; they educated the mind, body, emotions, and spirit, all a part of the human being. The idea that education is nothing but the brain, nothing but intellectual activity, is a fairly new idea to most American universities, and professional schools, especially, model themselves after graduate programs in Germany. As a result, a lot of values and sensitivities are negatively reinforced — just as I had done with Toby. I was saying that you are wrong, this other analysis is correct. One thing I later realized was that his approach had been to focus on the *person*. There was a certain respect for that person, for her wishes and rights of self-determination. And that does not always come from the mind, which is the only thing we reward in our professional schools.

To a great extent, we view the rest of the campus and say it is not quite good enough for us, so we stay at the law school. Lawyers are somewhere below us, the paralegals are somewhere under them, and our clients are at the bottom. There is the same kind of hierarchy in medicine: doctors, nurses, aides, and patients. Somewhere close to the bottom are the students, and I do not know who is "better" — the stu-

Topics often focused on unrealistic admissions criteria.

dents or the patients. Probably the students are on a higher rung. But we have the assumption that they are empty receptacles, and we have all the information. That only works, however, if your assumption is that the only things that count are analysis and intellectual ability. That is not to say these things are not important; they are. But often they are the only things considered, reinforced, and rewarded. Some of a person's other qualities (e.g., intuition) atrophy for lack of use and positive reinforcement in our professional schools.

My view on student admissions is that the only way it can best be accomplished (even before the Supreme Court ruled on the issue) is to realize that you have to redefine the qualities necessary to possess in order to be in the helping professions. Thus, to talk in terms of lower standards is selling ourselves short because there are so many areas in which we have higher standards that are not recognized. I will always remember Toby focusing on that *person* instead of on due process, and what he gave to the class with that contribution.

Admissions standards are largely numbers game, despite rhetoric to the contrary. Although we brag about admitting some minorities, we are sure that we tell them that their scores were not as good as others were. I recently came upon some interesting related information. The Educational Testing Service (ETS) in Princeton, New Jersey, is the hurdle that most of us have to pass. We need to pass it to get into college, into law school (LSAT test), into medical school (MCAT) — it is everywhere. The Educational Testing Service is an absolute monopoly. It is a nonprofit corporation whose profits have doubled every five years since 1948. In the last couple of years there has been much dissatisfaction with the LSAT test. Because no one can quite articulate what it is though, there is a group studying LSAT right now. Do you know who its members all work for? ETS. Even if the testing methods are valid — and to some extent they are — the test misses the point in one very important way. You cannot have only one criterion for admission. All of this has created what I call the incredible authoritarianism of our professional system; for example, the hierarchy of professionally trained people, the presumption that doctors are better than nurses because doctors have more education, so of course they know more. It seems to me that the medical profession, to a very large extent, has completely usurped the patients' rights. I am abdicating responsibility for myself by giving them total authority over my body.

We are so locked into this way of doing things that it runs through our professional lives and through our educational institutions where we train those for professions. The challenge now is primarily to get into the institutions, and, second, once you get in to somehow be able to preserve those sensitivities that Toby had when he observed the civil commitment hearing. Preserve those sensitivities and still do what the institution is telling you to do until you can get it to realize that there are *other* ways of looking at the world. That is the great dilemma we are faced with now.

Challenges were put forth in hopes of rallying participants into creating positive changes.

PART II:

RECOMMENDATIONS AND ISSUES FROM DISCUSSION GROUPS

Recommendations and Issues

I. Recruitment and Admissions

A. Problems

1. increase pool of students.
2. access to students.
3. support programs with qualified personnel in higher education.
4. lack of preparation of incoming students.
5. faculty sensitization to minorities and their problems.
6. access to information, i.e. statistics for admission committees.
7. provide professional health care to neglected and/or underserved areas.
8. how do we address the problem of recruiting "hard core" students.

B. Solutions/Recommendations

1. influence funding to include secondary and post secondary recruitment, stipends.
2. "clearing house" for information.
   a. lists of individuals with particular expertise.
   b. identify areas of critical shortages.
3. utilize the above clearing house and other programs with similar objectives to send letters of support with documentation to those agencies being dealt with.
4. implies the foundation of an organization to pay for mailings, etc.

II. Retention

1. newsletter.
2. communications network.
3. organization as advocacy group.
4. institutionalize programs.
5. faculty and support programs on hard money.
6. adequate staffing to provide support programs.
7. regional communication system.
8. categorize information for potential students from schools regarding professional programs, admission criteria, national test results, support programs, and licensure information.
9. ad hoc steering committee.
   a. funds to implement coalition.
   b. volunteer to participate as part of our respective positions to impact 1) financial aid legislation, 2) exchanging ideas on tutorial programs, 3) ranking of health professional programs in schools.

III. Legislative

1. develop support mechanism on local, state and federal level use "constituent power."
2. utilize existing systems, i.e. NCHO, WICHE, AAMC.
3. impact legislation, i.e. HR2525 Indian Health Care Improvement Act.
4. develop a chain of communication, i.e. send entire message or memo with your comments added.

Dr. Ramos summarized the discussion from the work groups in terms of identifying common issues, determining functions to implement action oriented activity and delineated feasible activities that could impact mutual goals of health science centers and consumers of health services. Participants identified the need for a community based advocacy group. He encapsulated the following issues:

1. an advocacy group to respond to health care delivery issues.
2. an advocacy group that can impact legislation that directly affects ethnic groups and their access to funds for equalization of opportunities.

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3. an advocacy group to devise an informational network to participate in planning strategies for quick response to and pressing issues.
4. an advocacy group to develop a position to impact civil rights legislation and implementation.

He conceptualized the following format for the group:

Functions

1. What does group stand for.
2. What is important to the group.
3. Need for steering committee or quasi-formal group.
4. Need to define the agenda; determine objectives and priorities.
5. Strategies/battle plans.
6. Implementation necessitated a nucleus of people.

Activities

1. Study Unit
   a. political pressure
   b. advocacy group
   c. lobbying
   d. education of public via press releases
2. Institute "alerts"
   a. clearing house
   b. exchange system
3. Coalition or allies are necessary composed of patients, students — providers.
4. Utilization of resources, i.e. Freedom of Information Act allows access to proposals.

Discussion of Above Model

1. What groups are represented at the conference? Minority health science, educators, counselors, recruiters and support personnel.
2. Accountability begins at home; how can this group hold recipients or institutions of grants accountable for activities related to increasing the number of ethnic minorities in the health care delivery system.
3. Utilize knowledge and skills already existing in the group to develop strategies and implement plans.
4. Utilize already existing avenues, i.e. newsletters for dissemination of information.
5. Need to develop communication network with a local — state — regional and national scope.
6. Need to define the primary area of interest — admissions, recruitment and retention — for the group and address these issues from a national perspective. Many current activities are only bandaids for the real issues.
7. Since funding is decreasing, it is imperative that the group define area of focus and concentrate all interest, expertise, and influence to impact the system.
8. Group cohesiveness and action is critical in developing a support group that will address legislation, court rulings, etc., particularly in relationship to our concerns regarding admission, special programs, etc.

Tentative Solutions

1. Define the scope as the health professions.
2. Strategy: play numbers game by combining strength of group to effect change.
3. Priority of issues as defined for all health professions
   a. recruitment
   b. admission
   c. retention
   d. affirmative action
   e. whole spectrum and levels of education
4. Activities:
   a. develop lobbying group, or work with established groups responsive to minority needs.
   b. apply pressure to representatives, senators and other elected officials; capitalize on "power of constituents."
   c. conduct research
   d. informational structure
      1. communication
      2. dissemination of information
      3. clearing house
      4. support mechanism
      5. mechanism for addressing critical issues and crisis.
   e. contact various organizations to develop a data bank or pool, i.e. American Association of Medical Colleges.

Actions

1. Develop communication network with representatives from each state responsible for contacting another state and local organizations.

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2. Ad Hoc Committee formed by those representing the sponsoring schools.
   a. develop an organizational format to be mailed to participants.
   b. select name for organization.
   c. mailings to participants.
   d. supply list of participants and identify contact persons for each state.
   e. address feasibility of obtaining funds for future conference (August or September recommended).

PART III:

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